STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155160		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY  A. BUILDING 01 COMPLETED  B. WING 02/17/2012			ETED	
VIDER OR SUPPLIER		990 N 16TH ST				
				, 10 122, IIV 17 002	ı	715)
				PROVIDER'S PLAN OF CORRECTION (FACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
				CROSS-REFERENCED TO THE APPROPRIA  DEFICIENCY)	TE	DATE
REGULATORT OR	ESC IDENTIFTING INFORMATION)		IAU	,		DATE
state Licensure She Indiana State coordance with a coordance Number: 10 coo	Department of Health in 42 CFR 483.70(a).  //17/12  000080  :: 155160  00289330  Bugni, Life Safety Code  ty Code survey, habilitation Centre & not in compliance with reparticipation in haid, 42 CFR Subpart afety from Fire and the ne National Fire iation (NFPA) 101, Life C), Chapter 19, Existing apancies and 410 IAC  cility was determined to 1) construction and fully dding the Administration in foyer. The facility has am with smoke detection	K00	000	admission by the provider of a conclusion set forth in the statement of deficiencies, or a violation of regulation. This provider respectfully requests the 2567 Plan of Correction be	iny iny that	
O TO COMPAND SHOW THE	VIDER OR SUPPLIER  SUMMARY ST  (EACH DEFICIENCE REGULATORY OR  A Life Safety Co tate Licensure Se the Indiana State eccordance with urvey Date: 02.  Cacility Number: Provider Number: AIM Number: 1  urveyor: Mark pecialist  At this Life Safet tonebrooke Reh uites was found dequirements for Medicare/Medica 83.70(a), Life S 000 edition of the rotection Assoc afety Code (LSC Lealth Care Occi 6.2.  Chis two story fa e of Type II (11 prinklered exclu lall storage room fire alarm syste	CORRECTION IDENTIFICATION NUMBER: 155160  VIDER OR SUPPLIER  DOKE REHABILITATION CENTRE & SUITES  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A Life Safety Code Recertification and tate Licensure Survey was conducted by the Indiana State Department of Health in ecordance with 42 CFR 483.70(a).  urvey Date: 02/17/12  acility Number: 000080 trovider Number: 155160  AIM Number: 100289330  urveyor: Mark Bugni, Life Safety Code pecialist  At this Life Safety Code survey, tonebrooke Rehabilitation Centre & uites was found not in compliance with tequirements for Participation in Medicare/Medicaid, 42 CFR Subpart 83.70(a), Life Safety from Fire and the 000 edition of the National Fire rotection Association (NFPA) 101, Life afety Code (LSC), Chapter 19, Existing lealth Care Occupancies and 410 IAC	VIDER OR SUPPLIER  DOKE REHABILITATION CENTRE & SUITES  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A Life Safety Code Recertification and tate Licensure Survey was conducted by the Indiana State Department of Health in eccordance with 42 CFR 483.70(a).  Turvey Date: 02/17/12  Facility Number: 000080  Trovider Number: 155160  LIM Number: 100289330  Turveyor: Mark Bugni, Life Safety Code pecialist  At this Life Safety Code survey, tonebrooke Rehabilitation Centre & uites was found not in compliance with dedicare/Medicaid, 42 CFR Subpart 83.70(a), Life Safety from Fire and the 000 edition of the National Fire rotection Association (NFPA) 101, Life afety Code (LSC), Chapter 19, Existing Itealth Care Occupancies and 410 IAC 6.2.  This two story facility was determined to e of Type II (111) construction and fully prinklered excluding the Administration Ital storage room foyer. The facility has fire alarm system with smoke detection	VIDER OR SUPPLIER  VIDER OR SUPPLIER  DOKE REHABILITATION CENTRE & SUITES  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A Life Safety Code Recertification and tate Licensure Survey was conducted by the Indiana State Department of Health in eccordance with 42 CFR 483.70(a).  urvey Date: 02/17/12  acility Number: 155160  All Number: 100289330  urveyor: Mark Bugni, Life Safety Code pecialist  At this Life Safety Code survey, tonebrooke Rehabilitation Centre & uites was found not in compliance with dequirements for Participation in Medicare/Medicaid, 42 CFR Subpart 83.70(a), Life Safety from Fire and the 000 edition of the National Fire rotection Association (NFPA) 101, Life afety Code (LSC), Chapter 19, Existing lealth Care Occupancies and 410 IAC 6.2.  This two story facility was determined to be of Type II (111) construction and fully prinklered excluding the Administration lall storage room foyer. The facility has fire alarm system with smoke detection	VIDER OR SUPPLIER  DOKE REHABILITATION CENTRE & SUITES  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  A Life Safety Code Recertification and tate Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a).  Survey Date: 02/17/12  acility Number: 100080  Trovider Number: 155160  JIM Number: 100289330  surveyor: Mark Bugni, Life Safety Code pecialist  At this Life Safety Code survey, tonebrooke Rehabilitation Centre & uites was found not in compliance with tequirements for Participation in fedicare/Medicaid, 42 CFR Subpart 83.70(a), Life Safety from Fire and the 000 edition of the National Fire rotection Association (NFPA) 101, Life afety Code (LSC), Chapter 19, Existing lealth Care Occupancies and 410 IAC 6.2.  This two story facility was determined to e of Type II (111) construction and fully prinklered excluding the Administration lall storage room foyer. The facility has fire alarm system with smoke detection	DENTIFICATION NUMBER: 155160  IDENTIFICATION NUMBER: 155160  IN WING  IDENTIFICATION NUMBER: 155160  IN WING  STREET ADDRESS, CITY, STATE, ZIP CODE  990 N 16TH ST  NEW CASTLE, IN 47362  ID  PREFIX  REGULATORY OR LSC IDENTIFYING INFORMATION)  IN COURT OF CONTROL OF THE APPROPRIATE  IDENTIFY OR LSC IDENTIFYING INFORMATION)  IN COURT OF CONTROL OF THE APPROPRIATE  IDENTIFY OR LSC IDENTIFYING INFORMATION)  IN COURT OR CONTROL OF THE APPROPRIATE  IDENTIFY OR CONTROL OF THE APPROPRIATE  IDENTIFY OR CONTROL OF THE APPROPRIATE  IDENTIFY OR CONTROL OF THE APPROPRIATE  IN COURT OF THE APPROPRIATE  IDENTIFY OR CONTROL OF THE APPROPRIATE  IDENTIFY ON

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (\*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

080000

PRINTED: 03/13/2012 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA  OF CORRECTION IDENTIFICATION NUMBER:  155160	(X2) MULTIPLE CO  A. BUILDING  B. WING	01	(X3) DATE SURVEY COMPLETED 02/17/2012
	PROVIDER OR SUPPLIER  ROOKE REHABILITATION CENTRE & SUITES	990 N 1	ADDRESS, CITY, STATE, ZIP CODE IGTH ST ASTLE, IN 47362	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION
	spaces open to the corridors. The facility has a capacity of 152 and had a census of 84 at the time of this visit.			
	Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 02/23/12.			
	The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			

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Event ID: QZDZ21

Facility ID: 000080

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	01	COMPLETED		
		155160	B. WING		02/17/2012		
NAME OF P	PROVIDER OR SUPPLIE	B	STREE	T ADDRESS, CITY, STATE, ZIP CODE			
				I 16TH ST			
STONEB	ROOKE REHABIL	ITATION CENTRE & SUITES	NEW	CASTLE, IN 47362			
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	NCY MUST BE PERCEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA			
TAG		R LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE		
K0017	NFPA 101	CODE STANDARD					
SS=E		eparated from use areas by					
		ed with at least ½ hour fire					
		g. In sprinklered buildings,					
		ly required to resist the					
		ke. In non-sprinklered					
		properly extend above the or walls may terminate at the					
		lings where specifically					
		de. Charting and clerical					
		areas, dining rooms, and					
		may be open to the corridor					
		onditions specified in the					
	-	os may be separated from n-fire rated walls if the gift					
	shop is fully spri	•					
	19.3.6.2.1, 19.3						
	Based on observ	vation and interview, the	K0017	K 0017 - It is the practice of th	ois 03/18/2012		
		ensure 3 of 14 hazardous		provider to maintain proper			
	1	shower rooms were		separation from the			
		he corridors. This		corridors. What corrective action(s) will be accomplished	l for		
	•	e affects all 57 residents		those residents found to have			
	•	ne first floor of the		been affected by the deficient			
	facility.			practice? - To regain the requ			
	idenity.			separation between corridors			
	Findings include	· ·		use areas all penetrations in t drywall above the drop ceiling			
	Findings include	<del>.</del> .		assemblies in the areas cited			
	Dagad on abasm	votions on 02/17/12 during		have been patched and			
		vations on 02/17/12 during		appropriately firestopped. Once			
		t floor from 10:25 a.m. to		completed all drop ceiling tiles were reinstalled or replaced a			
	•	the maintenance		needed. Additionally the	5		
	•	dministrator, the		Administration hall corridor dre	ор		
		loor hazardous area rooms		ceiling was reworked so there			
		enter Hall shower room		no gaps between the grid and			
	were open to the corridor:			ceiling tiles. How other reside			
	a. The first floor	Administration Hall		having the potential to be affe by the same deficient practice			
	storage room, w	hich was a hazardous area	1	be identified and what correct			

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Event ID: QZDZ21

Facility ID: 000080

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLI	
		155160	B. WIN	G		02/17/	2012
NAME OF F	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					6TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΤE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	action(s) will be taken? - All		DATE
		e hundred twelve square			residents who reside on the fir	st	
		cardboard boxes of			floor of the facility have the		
		er and plastic office			same potential to be affected to		
		drop ceiling tiles			the deficient practice. Through		
		g four, three inch to six			facility maintenance inspection issues such as the above are	IS IT	
	_	enetrations in the drywall			found they will be repaired. Wi	nat	
	_	eiling assembly with no			measures will be put into place	e or	
	fire stopping mat				what systemic changes will be		
	*	veen the storage room			made to ensure that the deficience practice does not recur? -	ent	
		tration Hall corridor.			Through the facility Maintenan	ce	
	· · · · · · · · · · · · · · · · · · ·	Administration Hall			Directors building inspections		
	•	ling assembly had one			done 5 days per week , if such	1	
	-	e half inch gaps where			issues such as the above are	lovu	
		assembly metal rails were			found , they will be repaired. He the corrective action(s) will be	low	
		allowing the drop ceiling			monitored to ensure the deficie	ent	
	tiles to sit flush i				practice will not recur,i.e.,what		
		Center Hall boiler room			quality assurance program will		
	hazardous area, v	which was a fuel fired			put into place? - Data collected Maintenance Director through	-	
	equipment room,	had twelve drop ceiling			inspections will be submitted to		
	tiles missing exp	osing ten, two inch to six			CQI committee for review and		
	inch horizontal p	enetrations in the drywall			follow up. By what date the		
	above the drop co	eiling assembly with no			systemic changes will be	ί.	
	fire stopping mat				completed? - Compliance date March 18, 2012	,. 	
	penetrations bety	veen the storage room			,		
	and the Center H	all corridor and the					
	nurses' office to	the south of the storage					
	room. Furthermo	ore, the Center Hall					
	corridor drop cei	ling assembly had one					
	eighth inch to on	e half inch gaps where					
	the drop ceiling a	assembly metal rails were					
	warping and not	allowing the drop ceiling					
	tiles to sit flush i	n the metal rails.					
İ	c. The first floor	Center Hall shower room					
	had ten drop ceil	ing tiles missing					
					l		

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Event ID: QZDZ21

Facility ID: 000080

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PRINTED: 03/13/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:  155160	A. BUII		01	COMPL: 02/17/	ETED
		193160	B. WIN			02/17/	2012
NAME OF P	ROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
STONEB	ROOKE REHABILIT	TATION CENTRE & SUITES			6TH ST ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	*	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCI)		DATE
	exposing six, two						
	•	ations in the drywall					
	•	eiling assembly with no					
	fire stopping mat						
	-	veen the shower room					
		all nurses' station					
		soiled linen room to the					
	east of the showe						
		Center Hall boiler room					
		which was a fuel fired					
		had twelve drop ceiling					
		osing ten, two inch to six					
	_	enetrations in the drywall					
	_	eiling assembly with no					
	fire stopping mat						
	•	veen the storage room					
		all corridor and the					
		the south of the storage					
		ore, the Center Hall					
	•	ling assembly had one					
	-	e half inch gaps where					
		ssembly metal rails were					
		allowing the drop ceiling					
		n the metal rails. The					
		istration Hall storage					
	-	s above the ceiling, the					
	first floor Center						
		the first floor Center					
		n penetrations which					
		ped and the drop ceiling					
		allowing the ceiling					
	tiles to sit flush in	n the metal rails was					
		enance supervisor and					
	administrator at t	he time of observations.					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QZDZ21

Facility ID: 000080

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	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA DEFICIES X1) PROVIDER/SUPPLIER/SUPP	(X2) MULTIPLE CO A. BUILDING B. WING	01	(X3) DATE SURVEY COMPLETED 02/17/2012		
	ROOKE REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE  990 N 16TH ST  NEW CASTLE, IN 47362				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE		
	3.1-19(b)					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QZDZ21

Facility ID: 000080

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STATEMEN	T OF DEFICIENCIES	) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE			NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPLETED	
		155160	B. WING			02/17/	2012
NAME OF B	DOWNER OF GUIDNIED			STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			990 N 1	6TH ST		
		TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG K0029	REGULATORY OR NFPA 101	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
SS=E	LIFE SAFETY C One hour fire rat fire-rated doors) fire extinguishing 8.4.1 and/or 19.3 areas. When the extinguishing sys areas are separa	ODE STANDARD  ed construction (with ¾ hour or an approved automatic g system in accordance with 3.5.4 protects hazardous e approved automatic fire stem option is used, the ated from other spaces by partitions and doors. Doors					
	are self-closing a protective plates inches from the beginning the permitted.	and non-rated or field-applied that do not exceed 48 pottom of the door are 3.2.1					
	facility failed to to 3 of 14 hazard room were providevices which calciose and latch in deficient practice residents who used dining room, local from the first flow.  Findings include  Based on observation at the first floor boiles second floor Ash which measured	ation on 02/17/12 during lity from 10:25 a.m. to the maintenance dministrator, the doors to filer room door and the twood Hall supply room two hundred fifty square	K00	29	K 0029 It is the practice of this provider to provide doors with closing devices when applicable. What corrective action(s) will be accomplished for those resider found to have been affected by the deficient practice? Self closing devices were installed the first floor boiler room and second floor Ashwood Hall supproom doors. Additionally the soiled laundry room door was reworked and adjusted to close and latch appropriately. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? - All residents of the facility have the same potential to be affected by the deficient practice. Through facility maintenance inspection issues such as the above are found they will be repaired. When the deficient will be repaired.	self le. e e nts  on opply e e oy s if	03/18/2012
	feet and stored fo	orty nine combustible of paper, and plastic			measures will be put into place what systemic changes will be made to ensure that the deficie	e or	

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Event ID: QZDZ21

Facility ID: 000080

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PRINTED: 03/13/2012 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION IDENTIFICATION NUMBER:  155160	A. BUILDING  B. WING	COMPLETED 02/17/2012
	PROVIDER OR SUPPLIER  BROOKE REHABILITATION CENTRE & SUITES	STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES  (EACH DEFICIENCY MUST BE PERCEDED BY FULL  REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	E COMPLETION
	supplies, were not provided with self closing devices. Furthermore, the door to the soiled laundry room which measured two hundred eighty square feet was equipped with a self closing device, but the door failed to close and latch because it was propped open four feet on the concrete floor where the door bottom dragged on the floor. The first floor boiler room door and Ashwood Hall supply room doors lacking self closing devices and the soiled laundry room door not self closing and latching was verified by the maintenance supervisor and administrator at the time of observations.  3.1-19(b)	practice does not recur? - Through the facility's Maintenance Directors build inspections done 5 days per , if such issues such as the are found, they will be repai How the corrective action(s) be monitored to ensure the deficient practice will not rec i.e., what quality assurance program will be put into plac Data collected by Maintenan Director through his inspect will be submitted to CQI committee for review and fo up. By what date the system changes will be completed? Compliance date: March 18 2012.	rweek above red. will eur, ee? - nce ons llow nic -

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Event ID: QZDZ21

Facility ID: 000080

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PRINTED: 03/13/2012 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155160		A. BUII	(X2) MULTIPLE CONSTRUCTION  A. BUILDING  B. WING		(X3) DATE SURVEY  COMPLETED  02/17/2012	
	PROVIDER OR SUPPLIER			990 N 1	ADDRESS, CITY, STATE, ZIP CODE		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	FATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
K0038 SS=E	Exit access is an readily accessible with section 7.1.  1. Based on obset the facility failed accesses supplied locks and signs in ALARM SOUND OPENED IN 15 when force was a devices. 7.2.1.6. listed, delayed-expermitted to be in low and ordinary buildings protect approved, supervedetection system Section 9.6, or an automatic sprink with Section 9.7, Chapters 12 through following criteria process shall release device reshall not be required to be more than 3 seconds upon apprelease device reshall not be required to be more than 3 seconds upon 15 cm	ode standard ranged so that exits are e at all times in accordance 19.2.1 ervation and interview, to ensure 2 of 10 exit divith delayed egress indicating PUSH UNTIL DS DOOR CAN BE SECONDS, unlocked applied to the releasing 1, requires approved, gress locks shall be installed on doors serving by hazard contents in ed throughout by an insed automatic fire in accordance with a approved, supervised alter system in accordance and where permitted in high 42, provided the are met: an irreversible ease the lock within 15 polication of a force to the equired in 7.2.1.5.4 that are to exceed 15 lbf nor continuously applied for ands. The initiation of the hall activate an audible inity of the door. Once is been released by the aree to the releasing grahall be by manual	K00	038	K 0038 It is the practice of this provider to maintain exit accesses supplied with delayer egress locks are functioning properly. It is the practice of the provider to also ensure sidewas surfaces on all exit sidewalks maintained to prevent elevation changes. What corrective action(s) will be accomplished those residents found to have been affected by the deficient practice? - The delayed egres locks on the Moving Forward I and the Administration Hall exidoors were adjusted to ensure proper functioning. To ensure sidewalks are maintained to prevent elevation changes a 4 section of the cottage sidewall and a 4x4 section of the kitche exit sidewalk have been replaced how other residents having the potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? - All residents of the facility have the same potential to be affected by the same potential to the provide the	ed  ais alk are are for  s Hall it e exit  x4 k en ced. e  he by n ns if hat e or e	03/18/2012

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QZDZ21

Facility ID: 000080

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	OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
		155160	B. WIN	G		02/17/	2012
NAME OF F	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE		
					6TH ST		
STONEB	ROOKE REHABILI	TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	·	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG			DATE
	I -	ception: Where approved			Through the facilty's Maintena Directors building inspections		
	•	having jurisdiction, a			done 5 days per week , if suc		
	1 -	ng 30 seconds shall be			issues such as the above are		
	_	deficient practice could			found, they will be repaired.		
		ts who reside on the			the corrective action(s) will be monitored to ensure the defici		
	Moving Forward	l Hall.			practice will not recur, i.e., wh		
					quality assurance program wi		
	Findings include	¢.			put into place?- Data collected	-	
					Maintenance Director through inspections will be submitted		
		ations on 02/17/12 during			CQI committee for review and		
		lity with the maintenance			follow up. By what date the		
	*	dministrator from 10:25			systemic changes will be		
	a.m. to 1:45 p.m.	., the Moving Forward			completed? - Compliance dat	e:	
	Hall exit door an	d the Administration			March 18, 2012.		
	Hall exit door we	ere each equipped with					
	delayed egress lo	ocks and signs on each					
	door which read	PUSH UNTIL ALARM					
	SOUNDS DOOF	R CAN BE OPENED IN					
	15 SECONDS.	Both doors failed to					
	unlock the magn	etic hold down devices					
	after pressure wa	as applied for thirty					
	seconds to the do	oor latching hardware on					
	three attempts at	each exit door. This was					
	verified by the m	naintenance supervisor					
	and administrato	r at the time of					
	observations.						
	3.1-19(b)						
	2. Based on ob	servation and					
	interview, the f	acility failed to					
	· ·	ewalk surfaces on 2					
	of 10 exit side						
	I		- 1		i		ı

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPLETED
		155160	B. WIN			02/17/2012
NAME OF F	PROVIDER OR SUPPLIER	8			ADDRESS, CITY, STATE, ZIP CODE	
STONER	ROOKE REHARII I	TATION CENTRE & SUITES			6TH ST ASTLE, IN 47362	
			-		AOTEE, IIV 47 302	
(X4) ID PREFIX				ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5) COMPLETION
TAG	`	REGULATORY OR LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	DATE
	maintained to	prevent elevation				
		7.1.6.2 requires				
	_	s in elevation of the				
		e shall not exceed				
		nges in elevation				
	exceeding 1/4	- <del>-</del>				
	exceeding 1/2					
	beveled 1 to 2.					
		eding 1/2 inch shall				
		a change in level				
	and shall be su	bject to the				
	requirements o	of 7.1.7. This				
	deficient practi	ce could affect 18				
	residents who	reside on the				
	Cottage Hall.					
	Findings includ	le:				
	Based on obse	rvation with the				
	maintenance si	upervisor and				
	administrator o	during a tour of the				
	facility on 02/1	7/12 from 10:45				
	a.m. to 1:45 p.	m., the Cottage exit				
	sidewalk and tl	he kitchen exit				
	sidewalk both	discharged from the				
	exit doors onto	concrete sidewalks				
	extending forty	feet and twenty				
	feet to the park					
		ces had a four foot				
	by four foot se	ction of broken and				
	heaving concre	te with one inch to				
	two inch chang	jes in the sidewalks				
	elevation. This	was verified by the				
	1		1			

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	OF CORRECTION	IDENTIFICATION NUMBER:  155160	A. BUILDING  B. WING	01	COMP	E SURVEY PLETED 7/2012
STONEB		TATION CENTRE & SUITES	990 N 1 NEW C	ADDRESS, CITY, STATE, ZIP 6TH ST ASTLE, IN 47362	CODE	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
		LSC IDENTIFYING INFORMATION) upervisor and		CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CC	ONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155160	A. BUI	LDING	01	COMPL	
	133100			G		02/17/	2012
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
STONEBROOKE REHABILITATION CENTRE & SUITES					I6TH ST ASTLE, IN 47362		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATION OF THE APPROPRIATION	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
K0045 SS=E	Illumination of m discharge, is arra single lighting fix area in darkness emergency lighti section 7.8.) 1 Based on observation facility failed to 10 exit means of the failure of any (bulb) would not darkness. LSC Sillumination be a any single lighting an illumination left-candle (2 lux). This deficient praceident using the residents who residents were requested as a cours of the facility facility were requested to the facility were each provide the Cottage Hall were each provide		K00	045	K 0045 It is the practice of the provider to maintain the prope illumination at exits. What corrective action(s) will be accomplished for those reside found to have been affected by the deficient practice? - To ensure proper lighting in exit means of egress, the single builght fixtures at the therapy roo exit, the cottage hall exit, and kitchen exit were replaced with two bulb fixtures. How other residents having the potential be affected by the same deficipractice will be identified and what corrective action(s) will be taken? - All residents of the facility have the same potential be affected by this deficient practice. Through facility maintenance inspections if issuch as the above are found the will be repaired. What measure will be put into place or what systemic changes will be made ensure that the deficient practices not recur? - Through the facility's Maintenance Directors building inspections done 5 daper week, if such issues such the above are found, they will repaired. How the corrective action(s) will be monitored to	nts y ulb m the to ent e I to ues ney es e to ce s ys as	03/18/2012

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155160		A. BUILDING  B. WING	01	COMPLETED 02/17/2012	
NAME OF PROVIDER OR SUPPLIER STONEBROOKE REHABILITATION CENTRE & SUITES			990 N 1	ADDRESS, CITY, STATE, ZIP CODE 6TH ST ASTLE, IN 47362	
(X4) ID PREFIX TAG		INT OF DEFICIENCIES T BE PERCEDED BY FULL ENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	
	these exit discharges in one bulb failed. The enbreaker panels were ob at 2:40 p.m. with the management outside exit lights on an breaker. The single but lighting fixtures were wantenance supervisor at the time of observation observation of the supervisor at the time of observation of the supervisor at the s	a darkness if the mergency generator served on 02/17/12 maintenance strator and listed in emergency lb emergency verified by the r and administrator		ensure the deficient practice we not recur, i.e., what quality assurance program will be put into place? - Data collected by Maintenance Director through inspections will be submitted to CQI committee for review and follow up. By what date the systemic changes will be complete? - Compliance date: March 18, 2012.	his O

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MUL	TIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILD	ING	01	COMPL	ETED	
	155160		B. WING			02/17/	2012
NAME OF B	DOLUMEN OF GLIPPI HER		• т	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIER			990 N 1	6TH ST		
		TATION CENTRE & SUITES		NEW C	ASTLE, IN 47362		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PROVIDER'S PLAN OF CORRECTION			(X5)	
PREFIX	, The state of the	CY MUST BE PERCEDED BY FULL		PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE		E	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	-	TAG	DEFICIENCY)		DATE
K0056	NFPA 101	ODE STANDARD					
SS=E		omatic sprinkler system, it is					
		rdance with NFPA 13,					
		Installation of Sprinkler					
		ride complete coverage for all					
		uilding. The system is					
		ned in accordance with NFPA the Inspection, Testing, and					
	i i	Water-Based Fire Protection					
		lly supervised. There is a					
	reliable, adequat	te water supply for the					
	system. Required sprinkler systems are equipped with water flow and tamper switches, which are electrically connected to the building fire alarm system. 19.3.5						
	i	ation and interview, the	K005	6	K 0056 It is the practice of this		03/18/2012
		ensure 1 of 9 corridors			provider to ensure that all		
	*	sprinklered. This			corridors are completely		
		e could affect any			sprinkled. What corrective action(s) will be accomplished	for	
	_	e the Administration			those residents found to have	101	
	Hall.				been affected by the deficient		
	11411.				practice? - To ensure that all		
	Findings include				areas of the facility are fully		
	Tillanigs include	•			sprinkled a sprinklehead was installed in the Administration I	Hall	
	Based on observa	ation on 02/17/12 at			corridor by PIPE Inc. on March		
	10:25 a.m. with t				8,2012. How other residents	.41	
	supervisor and a				having the potential to be affect by the same deficient practice		
	_	-			be identified and what correction		
	Administration Hall corridor outside the storage room had a two foot by two foot area in the corridor with no sprinkler				action(s) will be taken? - All		
					residents of the facility have th		
		ermore, there was a one			same potential to be affected by	•	
		tending from the ceiling			this deficient practice. Through facilty maintenance inspections		
		_			issues such as the above are	J 11	
	_	the corridor sprinkler			found they will be repaired. Wh	nat	
		full coverage to the			measures will be put into place		
		ver, located in the			what systemic changes will be	4	
	Administration F	Hall corridor. This was			made to ensure that the deficie	ent ————	

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I 155160		A. BUILD B. WING		<u>01</u>	COMPL 02/17/	ETED		
NAME OF PROVIDER OR SUPPLIER STONEBROOKE REHABILITATION CENTRE & SUITES			STREET ADDRESS, CITY, STATE, ZIP CODE 990 N 16TH ST NEW CASTLE, IN 47362					
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PF	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	(X5) COMPLETION DATE	
	verified by the mand administrator observation.  3.1-19(b)	naintenance supervisor r at the time of			practice does not recur?- Through the facility's Maintenance Director's building inspections done 5 days per wear, if such issues as the above a found, they will be repaired. He the corrective action(s) will be monitored to ensure the deficie practice will not recur, i.e., who quality assurance program will put into place?- Data collected Maintenance Director through inspections will be submitted to CQI committee for review and follow up. By what date the systemic changes will be complete? - Compliance date: March 18, 2012.	eek re low ent at be by his		

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  A. BUILDING	COMPLETED
155160 B. WING	02/17/2012
STREET ADDRESS, CITY, STATE, ZIP	CODE
NAME OF PROVIDER OR SUPPLIER  990 N 16TH ST	CODE
STONEBROOKE REHABILITATION CENTRE & SUITES NEW CASTLE, IN 47362	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDENS IN AN OF CO.	ORDECTION (X5)
PROVIDER'S PLAN OF CO PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX (EACH CORRECTIVE ACTION)  CROSS PERFERENCE TO THE	SHOULD BE COMPLETION
TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)	DATE
CROSS-REFERENCED TO THE	ce of this at generators and for 30 is the er to ensure e is from a corrective emplished for to have deficient reliability evice has rectren current thas been the of 2011 as as of our
minimum of 30 minutes. Chapter 3-5.4.2 exercised under load	
of NFPA 99 requires a written record of responsible for past fa	• •
inspection, performance, exercising testings are no longer	
period, and repairs for the generator to be	
regularly maintained and available for residents having the p	
inspection by the authority having be affected by the sar	me deficient
invisdiction. This deficient practice affect.	
what corrective action	
takon. 7 in rookonko k	-
inexactions of maintai	
I Based on a review of the Emergency Generator I I I I I I I	nance
I I documentation it cuc	
all residents in the facility.  Findings include:  Based on a review of the Emergency Generator  taken?- All residents of have the same potent affected by this deficient Through facility maint inspections of maintel	of the facility tial to be ent practice. enance
Monthly Load Test Log Book on 02/17/12 at 9:35 documentation, if such	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	LDING	01	COMPLETED
	155160		B. WIN			02/17/2012
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER				990 N 1	6TH ST	
		TATION CENTRE & SUITES			ASTLE, IN 47362	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	`	CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG		DATE
		rgency Generator Monthly k showed a monthly load test			corrected. What measures will put into place or what systemic	
		ruary 2011 for one minute			changes will be made to ensur	
	· ·	y load test. Based on an			that the deficient practice does	
		naintenance supervisor on			not recur?- Administrator will	
	02/17/12 at 9:45 a.n	n., the maintenance supervisor			review monthly documentation	
	•	us maintenance supervisor			generator load tests to ensure	
		cy generator during the			compliance. How the corrective action(s) will be monitored to	<b>5</b>
	1	ry 2011 monthly load test for a			ensure the deficient practice w	rill
		and shut the emergency his was verified by the			not recur,i.e., what quality	
	_	time of record review and			assurrance program will be pu	t
	interview.				into place?- Data collected by	
					Maintenance Director /	000
	3.1-19(b)				Administrator through inspection will be submitted to CQI	JIIS
					committee for review and follow	w
	2. Based on in	terview and record			up. By what date the systemic	
	review. the faci	lity failed to ensure			changes will be complete? -	
		I source for 1 of 1			Compliance date: March 18,	
		erators was from a			2012.	
		. NFPA 110, 1999				
		rd for Emergency				
	and Standby Po					
	Chapter 3, Eme	·				
		-1.1 Energy Sources				
	states the follo					
		e permitted for use				
	for the emerge	ncy power supply				
	(EPS):					
	a) Liquid petrol	leum products at				
	atmospheric pr	ressure				
	b) Liquefied petroleum gas (liquid					
	or vapor withdi	•				
	c) Natural or sy					
	Exception: For	•				
	-	locations where the				
	mistanations in	iocations where the				1

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	01	COMPL	
155160			B. WIN			02/17/	2012
NAME OF F	PROVIDER OR SUPPLIER	<u> </u>			ADDRESS, CITY, STATE, ZIP CODE		
STONED	DOOKE DEHABILI	TATION CENTRE & SUITES		990 N 1	61H S1 ASTLE, IN 47362		
STONEBROOKE REHABILITATION CENTRE & SUITES				<u> </u>	ASTLE, IN 47302	1	
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE
1110	probability of i		+				51112
	' '	pplies is high (e.g.,					
		ake, flood damage					
	or demonstrate	<del>-</del>					
		n-site storage of					
	an alternate en						
		ow full output of					
	the emergency	•					
		o be delivered for					
	'						
	the class specified shall be						
	required, with the provision for automatic transfer from the						
	primary energy						
	alternate energ						
	CMS (Centers f						
	Medicare/Medi						
	·	r of reliability from					
	· ·	vendor regarding					
	_	that must contain					
	the following:	that must contain					
	1. A statement	t of reasonable					
	reliability of the						
	delivery.						
	2. A brief desc	ription that					
		atement regarding					
	the reliability.  3. A statement that there is a low probability of interruption of the natural gas.  4. A brief description that						
		atement regarding					
	' '	ility of interruption,					
	l -	re of a technical					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  155160			LDING	NSTRUCTION  01	(X3) DATE COMPL <b>02/17</b> /	ETED	
NAME OF PROVIDER OR SUPPLIER STONEBROOKE REHABILITATION CENTRE & SUITES			<b>P</b> . W.	990 N 1	DDRESS, CITY, STATE, ZIP CODE 6TH ST ASTLE, IN 47362		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	·	oractice could affect					
	all residents, staff and visitors.  Findings include:  Based on interview with the maintenance supervisor and administrator on 02/17/12 at 10:15 a.m. during record review, the fuel source for the emergency generator was natural gas.  Additionally, based on an interview with the administrator, the facility did not have a letter from their natural gas provider including all the items above required for a letter confirming the reliability of a natural gas fuel source for an emergency generator. The lack of a letter from the natural gas provider was acknowledged by the administrator at the time of interview.  3.1–19(b)						

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